MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

56a

04355

CERTIFICATE OF DEATH

Reg. Dist. No. 290

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Talbot Co.

City or town: Easton Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8 days

Hospital, Institution, or street address where death occurred: Memorial Hospital

How long in hospital or institution? 8 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Talbot

City or town: Easton

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Glebe Road

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Mrs. Anna Mae Bennett

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	married

6.(b) Name of husband ~~or wife~~: Mr. Clell Bennett

6.(c) If alive, give age: 37 years

7. Birth date of deceased (mo., day, yr.): June 21, 1910

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
36	10	15		

9. Birthplace: Easton, Talbot - Maryland (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: At Home

FATHER — 12. Name: William Caulk

FATHER — 13. Birthplace: Easton, Md.

MOTHER — 14. Maiden name: Maggie Collins

MOTHER — 15. Birthplace: Easton, Md

18. Informant: William Caulk

Address: Easton, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 8, 1947 (month) (day) (year)

Cemetery or crematory: Spring Hill

Location: Easton, Md

18. Funeral director: T. Ellis Clark Funeral Home

Address: Easton, Md.

19. 5/6/1947 (Date rec'd by registrar) M. L. Nevins Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 6, 1947, at 2:25 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4 May 1947 to 6 May 1947 and that I last saw h~~im~~er alive on 4 May 1947

Immediate cause of death	DURATION
Cardiac failure.	24 hours
~~Coma~~ Uremia	2 days
Due to: Paralytic ileus	2 days
Due to:	
Other conditions: Endometriosis	?

(Include pregnancy within 3 months of death)

Major findings of operations: Endometriosis & ovarian cyst. Date of op. 29 April 47

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: James Harrison M.D.

M. D. or other

Address: 24 E. Dover St. Easton, Md. Date signed: May 7 47

RECEIVED
MAY 9 1947
BUREA

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 290

1. PLACE OF DEATH:
County: Talbot
City or town: Easton Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 mos
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Talbot
City or town: Easton R.D.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Chauncey K. Burgess
3.(b) Social Security Number

4. Sex: Male
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Widowed
6.(b) Name of husband or wife
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.): Dec 13 - 1854
8. AGE: Years: 92 Months: 4 Days: 27 If less than one day ... hrs. ... min.
9. Birthplace: Springport Michigan (Town, county, and state)
10. Usual occupation: Retired Farmer
11. Industry or business
12. FATHER Name: Lewis Burgess
13. FATHER Birthplace: Watertown, N.Y.
14. MOTHER Maiden name: Lydia M. Hughes
15. MOTHER Birthplace: New York
16. Informant: C. C. Burgess
Address: Newcomb, Md.
17. (Burial, cremation, or removal. Which?) Burial Date thereof: May 12 47 (month) (day) (year)
Cemetery or crematory: Springhill Cemetery
Location: Easton, Md.
18. Funeral director: John D. Mullikin
Address: Easton Md
19. 5/12 1947 M. H. Nevitt Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 10 1947 at 6450 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5 May 1947, to 10 May 1947
and that I last saw h. alive on 10 May 1947

	OURATION
Immediate cause of death: Congestive heart failure	2 mos
Due to:	
Due to:	
Other conditions: Infirmities of age	?

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of ...
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: O. J. Onkins M.D. M. D. or other
Address: Royal Oak, Md Date signed: 5/11-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A10 9-45-15M

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MAY 17 1947
BUREAU U. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

1318 64357

CERTIFICATE OF DEATH

Reg. Dist. No. 291

1. PLACE OF DEATH:
County: Talbot County
City or town: St. Michaels, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Talbot
City or town: St. Michaels
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME John Wallace Bush

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

6.(b) Name of husband or wife: Jessie Peterkin
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): October 5, 1865

8. AGE: Years	Months	Days	If less than one day
81	7	16	..... hrs. ..... min.

9. Birthplace: Central Valley, New York (Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business

FATHER
12. Name: unknown
13. Birthplace: unknown

MOTHER
14. Maiden name: Martha Ford
15. Birthplace: unknown

16. Informant: John M. Bush
Address: St. Michaels, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 24, 1947 (month) (day) (year)
Cemetery or crematory: Olivet
Location: St. Michaels, Md.

18. Funeral director: Newnam & Harrison
Address: St. Michaels, Maryland

19. May 23 19 47 (Date rec'd by registrar) Mrs. Pet L. Seth Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 22 19 47 at 8:00 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 9, 1947 to May 22, 1947 and that I last saw him alive on May 22, 1947

	DURATION
Immediate cause of death: Chronic Nephritis	2 years
Uraemia	12 Days
Due to: Hypertrophied prostate, (benign)	10 yrs.
Due to:	
Other conditions: Chronic Myocarditis	2 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Robert H. Brink, M.D.
M. D. or other
Address: St. Michaels, Md. Date signed: 5/22/47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
MAY 27 1947
BUREAU OF S

Evidence for change of age shown on:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83a

C4358

FILM No. G 110 MAY 22 1947 **CERTIFICATE OF DEATH**

Reg. Dist. No. 290

1. PLACE OF DEATH:
County: Talbot
City or town: Easton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 yrs.
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Talbot
City or town: Easton
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 16 S. Locust
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Evaline C. Collins

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	Col.	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Oct. 1. 1891

8. AGE: Years	Months	Days	If less than one day
55	7	7	hrs. min.

9. Birthplace: Talbot Co. (Town, county, and state)
10. Usual occupation: Laundress
11. Industry or business:

FATHER
12. Name: Solomon S. Collins
13. Birthplace: Talbot or Dorchester

MOTHER
14. Maiden name: Mary S. Campen
15. Birthplace: Dorchester

16. Informant: Laura E. Collins
Address: 16 S. Locust St. Easton, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 12 1947 (month) (day) (year)
Cemetery or crematory: Richards Cemetery
Location: Easton, Md.

18. Funeral director: Leon W. Henry
Address: 310 Dover St. Easton, Md.

19. 5/12 1947 (Date rec'd by registrar) N. S. Morris Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 8 1947 at 8.36 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 8 1947 to May 8 1947 and that I last saw h.e.r.m. alive on May 8 1947

Immediate cause of death	DURATION
Cerebral Hemorrhage	1 day
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Haywood T. Watt M.D.
M. D. or other
Address: Easton, Md. Date signed

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

6 17
1947-5-8
1891-10-1

55-7-7

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

61

04359

CERTIFICATE OF DEATH

Reg. Dist. No. 2-94

1. PLACE OF DEATH:
County Talbot
City or town Mc Daniel
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 35 -
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Talbot
City or town Mc. Daniel.
(If ontside city or towu limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veleran, name war none

3.(a) FULL NAME Charles T. Conway

3.(b) Social Security Number none.

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	married

6.(b) Name of husband or wife Janette Conway
6.(c) If alive, give age 60 years
7. Birth date of deceased (mo., day, yr.) Dec. 25-1883

8. AGE:

Years	Months	Days	If less than one day
63	4	10	hrs. min.

9. Birthplace White Haven. Md
(Town, county, and state)
10. Usual occupation Bartender
11. Industry or business

FATHER
12. Name Samuel B. Conway
13. Birthplace White Haven Md.

MOTHER
14. Maiden name Olivia Mitchell
15. Birthplace White Haven Md

16. Informant Mrs Janette Conway
Address Mc. Daniel Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 7. 1947 (month) (day) (year)
Cemetery or crematory Cemetery
Location Easton Md.

18. Funeral director Newnam & Harrison
Address St. Michaels. Md.

19. May 6 1947 G. Wesley Lowell Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH May 4 1947, at 1:15 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 4 1947, to May 4 1947
and that I last saw h. in. alive on May 4 1947

Immediate cause of death	DURATION
Chronic Myocarditis	6 yrs.
Due to	
Due to	
Other conditions Chronic Endocarditis	6 yrs.
Diabetes Mellitis	6 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

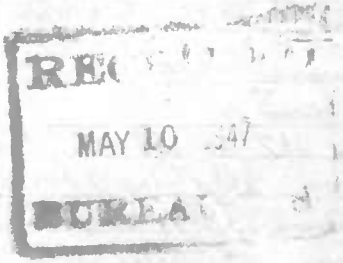
22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Robert H. Brink, M.D.
M. D. or other
Address St. Michaels, Md. Date signed May 6 1947

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING


MAY 10
BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

94a

04360

Reg. Dist. No. 290

1. PLACE OF DEATH:
County Talbot
City or town Easton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 12 years - 6 months
Hospital, Institution, or street address where death occurred: Home for Aged Women
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Talbot
City or town Easton
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Mary Louise Cooper

3.(b) Social Security Number None.

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	widow

6.(b) Name of husband or wife Alex Cooper
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Feb 19 1867

8. AGE:

Years	Months	Days	If less than one day
86	2	20	..... hrs. ..... min.

9. Birthplace Anne Arundel Co.
(Town, county, and state)
10. Usual occupation housewife
11. Industry or business

FATHER
12. Name Stephen Lark
13. Birthplace Wabash Ohio

MOTHER
14. Maiden name Anna E. Lockhold
15. Birthplace Marlboro Md.

16. Informant Home for Aged Women
Address Easton, Md.

17. Burial (Burial, cremation, or removal, Which?) Date thereof May 12 1947 (month) (day) (year)
Cemetery or crematory Ivy Hill Cemetery
Location Easton, Md.
19. Funeral director Maurice E. Thomas & Son
Address Easton, Md.

19. 5/12/47 (Date rec'd by registrar) M. H. Meredith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 9, 1947, at ..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1946 to 9 May 1947 and that I last saw h.er alive on April 1947

Immediate cause of death	DURATION
Coronary Thrombosis	?
Due to Arteriosclerosis	?
Due to	
Other conditions	

(Incinde pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underliue the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Thomas Harrison M. D. or other
Address 214 E. Dover, Easton Date signed 12 May 47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
MAY 17 1947
BUREAU OF S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 177

CERTIFICATE OF DEATH

04361

Reg. Diat. No. .....

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:
County: Talbot
City or town: Oxford (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 yrs
Hospital, institution, or street address where death occurred: /
How long in hospital or institution? .....

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County: Talbot
City or town: Oxford (If outside city or town limits, write RURAL and give nearest town)
Street No. ..... (If rural, give LOCATION)
2.(a) If veteran, name war .....

3. (a) FULL NAME: Pauline H. Cooper

3. (b) Social Security Number

4. Sex: F.
5. Color or race: Col
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: Walter H. Cooper
7. Birth date of deceased (mo., day, yr.): Jan 10, 1908
6.(c) If alive, give age ..... years

8. AGE: Years: 39 | Months: 4 | Days: 1 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Miami Fla (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business

FATHER
12. Name: William B. Smith
13. Birthplace: S. Ga

MOTHER
14. Maiden name: Mattie Thomas
15. Birthplace: Fla

16. Informant: Jesthina Jenkins
Address: 56 W 117 St Cast 10, N.Y.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 17 1947 (month) (day) (year)
Cemetery or crematory: Martinstown
Location: New Oxford, Talbot Co.

18. Funeral director: Geo. W. Seney
Address 316 South St. Easton Md.

19. May 17 1947 (Date rec'd by registrar) Josefa Corn Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 11 1947, at 5A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 10 1947, to May 11 1947
and that I last saw h.... alive on May 11 1947

	DURATION
Immediate cause of death: Gastro-Enteritis	2 days
Due to: Canned Fish	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Hayward T. Webb M.D. M. D. or other
Address: Easton, Md. Date signed 5/12/47

RECEIVED
MAY 19 1947
BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

CERTIFICATE OF DEATH

Reg. Dist. No. 04362 94

1. PLACE OF DEATH:
County: Talbot
City or town: Easton (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County: Talbot
City or town: Easton (If outside city or town limits, write RURAL and give nearest town)
Street No. (If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Thomas Henry Cooper

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	Widowed

6.(b) Name of husband or wife: Virginia
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): April 17, 1877

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
70	1	10		

9. Birthplace: Easton Talbot Co. Md (Town, county, and state)
10. Usual occupation: Merchant
11. Industry or business: Dept Store

FATHER
12. Name: Robert H. Cooper
13. Birthplace: Easton Md.

MOTHER
14. Maiden name: Mary E. Tarr
15. Birthplace: Bozman Md.

16. Informant: Robt H. Cooper
Address: Easton Md.

17. Burial (Burial, cremation, or removal? Which?) Date thereof 5-30-47 (month) (day) (year)
Cemetery or crematory: Easton M.E.
Location: Easton Md.

18. Funeral director: J. Norman Mitchell
Address: St. Michaels Md.

19. 5-30 (Date rec'd by registrar) 1947 J. Norman Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 27 1947, at 6P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1946, to May 27 1947
and that I last saw him alive on May 3 1947

Immediate cause of death	DURATION
Coronary occlusion	
Due to: Hypertension	2 years
Due to: Arterio Sclerosis	2 years
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D. or other
Address: Easton Md. Date signed May 28 1947

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
JUN 6 1947
BUREAU OF S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

04363

CERTIFICATE OF DEATH

Reg. Dist. No. 91

1. PLACE OF DEATH:

County: Talbot

City or town: Royal Oak (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Talbot

City or town: Royal Oak (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Fannie L. Denny

3.(b) Social Security Number: None

4. Sex: female

5. Color or race: white

6.(a) Single, married, widowed, or divorced: widowed

6.(b) Name of husband or wife: J. Hall Denny

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Oct, 28 1858

8. AGE: Years: 88 Months: 6 Days: 27 If less than one day: hrs. min.

9. Birthplace: Royal Oak, Maryland (Town, county, and state)

10. Usual occupation: House wife

11. Industry or business

FATHER 12. Name: Nicholas Leonard

FATHER 13. Birthplace: Royal Oak, Talbot Co. Md.

MOTHER 14. Maiden name: Mary Towsend

MOTHER 15. Birthplace: Royal Oak. Talbot Co, Md.

16. Informant: Mrs. William Denny

Address: Royal Oak, Talbot Co. Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 27 1947 (month) (day) (year)

Cemetery or crematory: Springhill Cemetery

Location: Easton, Maryland

18. Funeral director: Newnam & Harrison

Address: St. Michaels, Md.

19. May 26 1947 (Date rec'd by registrar) Mrs Robt. R. Seth Registrar

MEDICAL CERTIFICATION 47

20. DATE OF DEATH: May 25 1946, at 5 P.M.

21. I CERTIFY that death occurred on the date above stated: ~~that I attended deceased from~~ 19, to 19

and that I last saw h alive on 19

Immediate cause of death	DURATION
Chronic Myocarditis	
Due to: Senility	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Louis L. Watts M.D. M. D. or other

Address: Easton Md. Date signed 5-26-47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
MAY 28 1947
BUREAU V S

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Cap- Oxford. 83a 04364

Reg. Dist. No. 297

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

YS A15

1. PLACE OF DEATH: Talbot

County

City or town Oxford

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Entire life

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Talbot

City or town Oxford

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME George Herbert Dobson

3.(b) Social Security Number 216-09-4496

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	Married

6.(b) Name of husband or wife Mary Alice Dobson

6.(c) If alive, give age 51 years

7. Birth date of deceased (mo., day, yr.) March 7, 1892

8. AGE:

Years	Months	Days	If less than one day
55	2	4	....hrs. ....min.

9. Birthplace Oxford Talbot Co. Md.

(Town, county, and state)

10. Usual occupation Ship Carpenter

11. Industry or business

FATHER 12. Name William A. Dobson

13. Birthplace Oxford, Md.

MOTHER 14. Maiden name Ardelia Dobbs

15. Birthplace New York

16. Informant Mrs. Mary Alice Dobson

Address Oxford, Md.

17. Buried (Burial, cremation, or removal. Which?) Date thereof May 13 1947 (month) (day) (year)

Cemetery or crematory Oxford Cemetery

Location Oxford, Md. (rural)

18. Funeral director Maurice E. Dawson & Son

Address Easton, Maryland

19. May 15 1947 (Date rec'd by registrar) Registrar Frank A. Ross

MEDICAL CERTIFICATION

20. DATE OF DEATH May 11, 1947, at ....M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Jan 1947, to 5/11/1947

and that I last saw h. alive on 5-11-1947

Immediate cause of death	DURATION
Cerebral apoplexy	1 mo
Due to arteriosclerosis, generalized	1 years
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE B Cox M.D.

M. D. or other

Address Easton Md. Date signed 5/13/47

RECEIVED
MAY 16 1947
BUREAU OF S

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

83a not CB

04365

Reg. Diat. No. 794

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Talbot
City or town: Avalon
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 15 months
Hospital, institution, or street address where death occurred:
Avalon, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Massachusetts County: Suffolk
City or town: Boston
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Hannah Emily Jernberg

3.(b) Social Security Number: none

4. Sex: female
5. Color or race: white
6.(a) Single, married, widowed, or divorced: widowed
6.(b) Name of husband or wife: John G. Jernberg
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.): January 8, 1868
8. AGE: Years: 79 Months: 4 Days: 5 If less than one day: ..... hrs. ..... min.
9. Birthplace: Frederikshald, Norway (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business

FATHER
12. Name: Nils Thoresen
13. Birthplace: Frederikshald, Norway

MOTHER
14. Maiden name: Gurina Marie Anderson
15. Birthplace: Frederikshald, Norway

16. Informant: Gladys S. George
Address: Avalon, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 15, 1947 (month) (day) (year)
Cemetery or crematory: Cedar Grove Cemetery
Location: Boston, Mass.

18. Funeral director: Newnam & Harrison
Address: St. Michaels, Md.

19. 5/12 1947 (Date rec'd by registrar) G. B. Jameson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 12 May 1947, at 1.05 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9 July 1946, to 12 May 1947
and that I last saw h... alive on 10 May 1947

	DURATION
Immediate cause of death: Cerebro-vascular accident (Stroke)	25 days
Due to: Hypertension	unknown
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: none Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: M Herbert Harrison M. D., or other
Address: St Michaels, Md Date signed 12 May '47

RECEIVED
MAY 15 1947
BUREAU OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

25 04366

Reg. Diat. No. 290

1. PLACE OF DEATH:

County: Talbot

City or town: Easton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 da.

Hospital, institution, or street address where death occurred:

Memorial Hospital

How long in hospital or institution? 7 da.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Kent

City or town: Chestertown, Md. R. 2

(If outside city or town limits, write RURAL and give nearest town)

Street No.:

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Marjorie Johnson

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	B	married

6.(b) Name of husband ~~or wife~~: Wilbur Johnson

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
24				

9. Birthplace: Chestertown - Kent - Md. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER — 12. Name: Oscar Greenville

13. Birthplace: Hartford County, Md.

MOTHER — 14. Maiden name: Lillian Anderson

15. Birthplace: Kent County, Md.

16. Informant: Edward Kenny

Address: Rural Chestertown Md

17. (Burial, cremation, or removal. Which?) Burial Date thereof: May 20 1947 (month) (day) (year)

Cemetery or crematory: Georgetown Cem

Location:

18. Funeral director: A. Leroy Kenny

Address: Chestertown Md

19. 5/17 19 47 M. L. Nelms

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 17 1947, at 8 45 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

	DURATION
Immediate cause of death: Shock	8 hrs.
Due to: Hemorrhage ?	?
Due to: Erosion of Pelvic vessels ?	?
Other conditions: Salpingitis and gonorrhoea in patient 5/25/47 dead	

(Include pregnancy within 3 months of death)

Major findings of operations: Severe Salpingitis & Cystic Ovaries bilateral Date of op. 5/18/47

Autopsy results: Not obtained

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: J. T. B. Ambler M.D.

M. D. or other

Address: Easton Md Date signed: 5/21/47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
MAY 24 1947
BUREAU OF S

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04367

88

Reg. Dist. No. 290

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Talbot

City or town: Easton, md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: Memorial Hospital

How long in hospital or Institution? 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: County:

City or town:

(If outside city or town limits, write RURAL and give nearest town)

Street No.:

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME Edward Kellum

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
m	B.	✓

6.(b) Name of husband or wife: Unknown

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Unknown

8. AGE: Years	Months	Days	If less than one day
Approx 30			hrs. min.

9. Birthplace: Unknown (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business

FATHER — 12. Name: Unknown

13. Birthplace

MOTHER — 14. Maiden name: Unknown

15. Birthplace

16. Informant: Leon W. Henry

Address: Easton Md

17. Buried (Burial, cremation, or removal. Which?) Date thereof 5/12/47 (month) (day) (year)

Cemetery or crematory: Ephrata Va

Location: Ephrata Va

18. Funeral director: Leon W. Henry

Address: 310 South St Easton Md.

19. 5/13/47 (Date rec'd by registrar) M. A. Meredith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 10 19 47 at 11:12 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... to 10 May 19 47 and that I last saw him alive on 10 May 19 47

Immediate cause of death: Purulent meningitis — DURATION: ?

Due to: Orbital cellulitis — DURATION: ?

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results: See above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Thurston Harrison M.D. M. D. or other

Address: Easton, Maryland Date signed: 6 May 47

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MAY 26 1947
BUREAU V S

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

55

04368

CERTIFICATE OF DEATH

Reg. Dist. No. 294

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
County Talbot
City or town Tilghman
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? life
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Talbot
City or town Tilghman
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME J. Wesley Lednum
3. (b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife Evelyn S. Fairbank
6.(c) If alive, give age 44 years
7. Birth date of deceased (mo., day, yr.) August 4, 1902

8. AGE: Years	Months	Days	If less than one day
44	8	27	... hrs. ... min.

9. Birthplace Tilghman
(Town, county, and state)
10. Usual occupation Waterman
11. Industry or business
FATHER
12. Name Charles T. Lednum
13. Birthplace Tilghman
MOTHER
14. Maiden name Virginia Sinclair
15. Birthplace Tilghman
16. Informant Mrs. J.Wesley Lednum
Address Tilghman, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof May 3, 1947 (month) (day) (year)
Cemetery or crematory Cemetery
Location Tilghman,Md.
18. Funeral director Newnam & Harrison
Address St.Michaels, Md
19. May 3 1947 (Date rec'd by registrar) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 1 1947, at 4 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1946 to May 1 1947
and that I last saw him alive on April 30 1947

	DURATION
Immediate cause of death Starvation malnutrition	
Due to unable to swallow	3 wks
Due to tumor oesophagus	2 mos
Other conditions Tumor trachea [illegible]	6 yrs
Tumor malignant: Primary site: Back of middle ear in Bone [illegible]	5 yrs

(Include pregnancy within 3 months of death)
Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE [signature] M. D. or other
Address [illegible] Date signed May 3 1947

VS A15

tumor oesophagus

RECEIVED
MAY 6 1947
BUREA

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

159

04369

CERTIFICATE OF DEATH

Reg. Dist. No. 29a

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

County Talbot

City or town Easton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 hrs Minn

Hospital, Institution, or street address where death occurred: Memorial Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Queen Anne's

City or town Queenstown

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Baby Boy Lloyd

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	W	

6.(b) Name of husband or wife Howard William Lloyd

6.(c) If alive, give age 21 years

7. Birth date of deceased (mo., day, yr.) May 11-1947.

8. AGE: Years	Months	Days	If less than one day
			hrs. 35' min.

9. Birthplace Easton, Md Talbot

(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name Howard William Lloyd

13. Birthplace Wye Mills

MOTHER 14. Maiden name Margie Coois

15. Birthplace New York

16. Informant Margie Lloyd

Address Queenstown, Md.

17. Cremation (Burial, cremation, or removal. Which?) Date thereof 5/11/47 (month) (day) (year)

Cemetery or crematory Memorial Hosp.

Location Memorial Hosp - Easton

18. Funeral director Memorial Hospital

Address Easton Md.

19. 5/11 19 47 (Date rec'd by registrar) N. S. Merrill Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-11-47 19 47, at 2 17 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 5-11-47 1 45 P.M. to 2 15 P.M. 19 47

and that I last saw h alive on 5-11-47 19

Immediate cause of death Prematurity

	DURATION
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE William C. Lamb MD

M. D. or other

Address Queenstown Md Date signed May 12 1947

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MAY 26 1947
BUREAU U. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

1758

CERTIFICATE OF DEATH

04370-90 Reg. Diat. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Talbot

City or town Eastaw

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 18 da

Hospital, institution, or street address where death occurred:

Eastern Memorial Hospital

How long in hospital or institution? 18 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Talbot

City or town Eastaw

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Walter E. McDaniel

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	B	married

6.(b) Name of husband or wife Rachel McDaniel

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1881

8. AGE: Years	Months	Days	If less than one day
66			hrs. min.

9. Birthplace Trappe - Talbot Co. - Maryland (Town, county, and state)

10. Usual occupation Laborer

11. Industry or business Farmer

FATHER 12. Name James McDaniel

13. Birthplace Trappe, Md.

MOTHER 14. Maiden name Susan Holmes

15. Birthplace Trappe, Md.

16. Informant Rachel McDaniel

Address Easton Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5/5/47 (month) (day) (year)

Cemetery or crematory Trappe

Location Trapple Md

16. Funeral director Leonard Bontempo

Address 310 South St. Easton Md.

19. 5/2 19 47 (Date rec'd by registrar) N. H. Norris Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-1- 19 47, at 10 a.m. M

21. I CERTIFY that death occurred on the date above stated; ~~that I attended deceased from~~

19, to 19

and that I last saw h alive on 19

Immediate cause of death — DURATION

Septic Meningitis — Under

Due to Fractured Skull

Due to Fall from horse

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of 4-14-47

Where did injury occur? in Easton (City or town) Talbot (County) Md (State)

Injured at home, farm, industry, public place (where?) farm

Means of injury fall from horse Injured at work? Yes

23. SIGNATURE Louis A. Hatford M.D. M. D. or other

Address Easton Md. Date signed 5-2-47

RECEIVED
MAY 7 1947
BUREAU OF S

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d 04371

CERTIFICATE OF DEATH

Reg. Dist. No. 27

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Talbot
City or town: Oxford
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 37 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Talbot
City or town: Oxford
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Edith P. Newnam

3. (b) Social Security Number None

4. Sex: Female
5. Color or race: white
6.(a) Single, married, widowed, or divorced: Widow
6.(b) Name of husband or wife: William B. Newnam
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.): Oct. 20, 1850

8. AGE: Years: 96 Months: 6 Days: 18 If less than one day ..... hrs. ..... min.

9. Birthplace: Talbot Co. Md. (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business:
FATHER 12. Name: Thomas Parsons
13. Birthplace: Talbot Co. Md
MOTHER 14. Maiden name: Susan Ann Benson
15. Birthplace: Talbot Co. Md.
16. Informant: Maurice E. Newnam
Address: Trappe, Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof May 10 1947 (month) (day) (year)
Cemetery or crematory: Spring Hill
Location: Easton, Md.
18. Funeral director: Maurice E. Newnam Son
Address: Easton, Md.
19. May 9 1947 (Date rec'd by registrar) Joseph A. Corkran Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 8, 1947, at 5 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 6 1947, to May 8 1947
and that I last saw her alive on May 7 1947

Immediate cause of death	DURATION
Coronary thrombosis	48 hrs
Due to: Arterio sclerosis	10 yrs
Due to: Chronic myocarditis	8 yrs
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Joseph A. Corkran M. D. or other
Address: Trappe, Md. Date signed: 5/9/47

RECEIVED
MAY 12 1947
BUREAU OF S

Dr Harrison

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

04372

CERTIFICATE OF DEATH

Reg. Diat. No. 290

1. PLACE OF DEATH:

County Talbot

City or town Easton, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Memorial Hospital, Easton

How long in hospital or institution? 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Caroline

City or town Federalsburg, Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME William W. Parker

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	married

6.(b) Name of husband or wife Clara Parker

6.(c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.) Feb. 2, 1882

8. AGE: Years	Months	Days	If less than one day
64	3	9	..... hrs. ..... min.

9. Birthplace Bridgeville R7 D
(Town, county, and state)

10. Usual occupation Hardware Store

11. Industry or business Operator

FATHER 12. Name Joseph W. Parker

13. Birthplace Del.

MOTHER 14. Maiden name Ida Merrine

15. Birthplace Del.

16. Informant W. W. Parker

Address Federalsburg Md

17. Burial Date thereof May 18, 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Hill Crest

Location Federalsburg Md

18. Funeral director Harvey Williams

Address Federalsburg Md.

19. 5/17/1947 N. H. Nevins
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 16 1947, at 10 25 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 1946, to May 1947

and that I last saw h... alive on 16 May 1947

Immediate cause of death Cardiac failure — DURATION 24 hrs

Due to Arteriosclerotic coronary thrombosis — 24 hrs.

Due to

Other conditions Secondary anemia — 1 year

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Thurston Harrison M.D.
M. D. or other

Address 214 E. Dover St. Easton Date signed 17 May 47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

RECEIVED
MAY 24 1947
BUREAU V S.

Gr. Cof

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

469

C4373

CERTIFICATE OF DEATH

Reg. Dist. No. 29

1. PLACE OF DEATH:

County Talbot

City or town Easton Memorial Hospital
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 21 days

Hospital, institution, or street address where death occurred:
Memorial Hospital

How long in hospital or institution? 21 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Talbot

City or town Easton
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Mr Clarence Parrott

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	married

6.(b) Name of husband or wife Mrs. Hilda Parrott

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 9, 1902

8. AGE: Years	Months	Days	If less than one day
45	2	12	hrs. min.

9. Birthplace Talbot Co. Md.
(Town, county, and state)

10. Usual occupation Waterman

11. Industry or business

FATHER 12. Name Herbert Parrott

13. Birthplace Talbot Co.

MOTHER 14. Maiden name Martha Sowers

15. Birthplace Talbot Co.

16. Informant Mrs. Hilda Parrott

Address Oxford, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5/24/47 (month) (day) (year)

Cemetery or crematory Spring Hill

Location Easton

18. Funeral director P. Ellis Clark Jr.

Address Easton, Md.

19. 5/21/1947 (Date rec'd by registrar) N. B. Merrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 21, 1947, at 5 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from August 1946, to 5-21-1947

and that I last saw h alive on 5-20-1947

Immediate cause of death	DURATION
Carcinoma of pancreas	1 year
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Carcinoma of pancreas Date of op. 1/3/47

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE B Cof Md
M. D. or other

Address Easton Md. Date signed 5-24-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

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MAY 26 1947
BUREAU U. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

46a

04374

CERTIFICATE OF DEATH

Reg. Dist. No. 290

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:

County: Talbot

City or town: Easton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 22 days

Hospital, Institution, or street address where death occurred:

Memorial Hospital

How long in hospital or institution? 22 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Caroline Co.

City or town: Greens Boro

(If outside city or town limits, write RURAL and give nearest town)

Street No.:

(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Ida Bell Warner

3.(b) Social Security Number: 213-24-1845

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	B	married

6.(b) Name of husband or wife: Linwood Warner

6.(c) If alive, give age: 36 years

7. Birth date of deceased (mo., day, yr.): 1913 No record

8. AGE: Years: 34 Months: Days: If less than one day: hrs. min.

9. Birthplace: Greensboro Md (Town, county, and state)

10. Usual occupation: H. W.

11. Industry or business

FATHER — 12. Name: Clamp Brown

13. Birthplace: Greensboro Md

MOTHER — 14. Maiden name: Lola Maker

15. Birthplace: Greensboro, Md.

16. Informant: Linwood Warner

Address: Greensboro Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 11, 1947 (month) (day) (year)

Cemetery or crematory: Union

Locafion: Near Greensboro Md.

18. Funeral director: Raymond B. Rawlings

Address: Greensboro, Md.

19. 5/16/47 (Date rec'd by registrar) M. H. Norris Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 5/7/47, at 7 15 p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 16 Apr 1947 to 7 May 1947 and that I last saw h.. alive on 7 May 47 1947

Immediate cause of death	DURATION
Carcinoma of the esophagus	?
Due to:	
Due to:	
Other conditions: Lung abscess	3 wks

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Thurston Harrison M.D. M. D. or other

Address: Easton Maryland Date signed: May 9 47

RECEIVED
MAY 17 1947
BUREAU V S

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

94a

04575

Reg. Diat. No. 296

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Talbot.

City or town Easton.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DEACESED:

(For newborn infants give residence of mother)

State Md. County Talbot.

City or town Easton

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Katherine Cecilia Warrington

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W.	Widowed

B.(b) Name of husband or wife Wm Warrington

B.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 16, 1870.

8. AGE: Years	Months	Days	If less than one day
77	4	27	hrs. min.

9. Birthplace Talbot County, Maryland

(Town, county, and state)

10. Usual occupation Housekeeper.

11. Industry or business

FATHER 12. Name Patrick Ryan

13. Birthplace Ireland

MOTHER 14. Maiden name Celia Mc Hale

15. Birthplace Md.

16. Informant Mrs. Alice Price.

Address Easton. Md.

17. Buried Date thereof May 14 1947

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Spring Hill

Location Easton. Md.

18. Funeral director A. Elie Bank

Address Easton. Md.

19. 5/13 1947 M. H. Nevins

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 12 1947, at 2 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19, to 19

and that I last saw h alive on 19

Immediate cause of death	DURATION
Coronary Thrombosis	
Due to Arteriosclerosis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE M. V. Palmer M. D.

M. D. or other

Address Easton, Md. Date signed 5/13/47

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MAY 17 1947
BUREAU OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

92d

Reg. Dist. No. 04376 948

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS/A15

1. PLACE OF DEATH:
County: Talbot
City or town: Sherwood (Rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Talbot
City or town: Sherwood (Rural)
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Clara Webb.

3.(b) Social Security Number: 217-14-8800

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Col	Widowed

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Oct. 23, 1883

8. AGE: Years	Months	Days	If less than one day
63	6	15	hrs. min.

9. Birthplace: Sherwood, Talbot Co. Md.
(Town, county, and state)
10. Usual occupation: Canning House Worker
11. Industry or business: Packing House
FATHER 12. Name: George Grace
FATHER 13. Birthplace: Sherwood Md.
MOTHER 14. Maiden name: Lockerman
MOTHER 15. Birthplace: Sherwood Md.
18. Informant: Annie Dennis
Address: Sherwood Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: 5-10-47 (mnnth) (day) (year)
Cemetery or crematory: Sherwood Col.
Location: Sherwood Md.
18. Funeral director: J. Warren Mitchell
Address: St. Michaels Md.
19. May 9 19 47 G. Wesley Sewell Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 8 19 47, at 1 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1 19 47, to May 8 19 47
and that I last saw h. alive on May 7 19 47

Immediate cause of death	DURATION
Congestive heart failure	2 days
Due to: Chronic valvular heart disease	5 yrs.
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Gwynn Reese M.D.
M. D. or other
Address: Tilghman Md. Date signed: May 9 1947

RECEIVED
MAY 16 1947
BUREAU U. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Dr Lederer

13b

04377

Reg. Diat. No. 290

1. PLACE OF DEATH

County: Talbot

City or town: Cordova

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Talbot

City or town: Cordova

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Charles H. Williams

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Divorced

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): February 13-1900

8. AGE:

Years	Months	Days	If less than one day
47-	3	1	..... hrs. ..... min.

9. Birthplace: Cordova (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: Garage Work

FATHER

12. Name: Charles Williams

13. Birthplace: Cordova Md

MOTHER

14. Maiden name: Mary Dolvin

15. Birthplace: Cordova, Md.

16. Informant: Estelle Downs

Address: Cordova, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May-17-1947 (month) (day) (year)

Cemetery or crematory: Old Chapel Cemetery

Location: Cordova RFD. Md.

18. Funeral director: John D. Williams

Address: Easton Md.

19. 5/16 1947 (Date rec'd by registrar) N. H. Meeres Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May-14- 1947 at 5:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 7 1947 to May 14 1947 and that I last saw him alive on May 7 1947

Immediate cause of death: T. B. of the Lungs — DURATION: Chronic

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Knud Lederer M.D. M. D. or other

Address: Queen Anne Md Date signed: 5/15/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Be sure correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9.45-15M

RECEIVED
MAY 24 1947
BUREAU OF S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04378

Reg. Diat. No. 290

1. PLACE OF DEATH:
County Talbot Co.
City or town Easton Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
Memorial Hospital
How long in hospital or institution? 6 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Queen Anne
City or town Centreville
(If ontside city or town limits, writs RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war V

3. (a) FULL NAME Robert Allen Williams

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	Black	Single

6.(b) Name of husband or wife
B.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1943

8. AGE: Years 4 | Months | Days | If less than one day hrs. min.

9. Birthplace Centreville-Queen Anne-Md.
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name Ray Williams
13. Birthplace Virginia

MOTHER
14. Maiden name Agnes Scott Williams
15. Birthplace Centreville, Md.

16. Informant Agnes Scott Williams
Address Centreville Maryland.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 16-47 (month) (day) (year)
Cemetery or crematory Chesterfield
Location Centreville Maryland

18. Funeral director Dalton Bros
Address Centreville Maryland

19. 5/15 1947 N. H. Merrins Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH May 14, 1947 19 at 11:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 9 1947 to May 14 1947 and that I last saw him alive on May 14 1947

Immediate cause of death	DURATION
Tetanus	6 days
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Antopsy results
PHYSICIAN: Please nnderline the canse to which death shonld he charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (Conuty) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Thurston Harrison M.D. M. D. or other
Address Easton Maryland Date signed May 15 47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

RECEIVED
MAY 24 1947
BUREAU V S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

043719

83a

Reg. Diat. No. 290

1. PLACE OF DEATH:

County Talbot

City or town Easton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution or street address where death occurred:

Stewart Nursing Home

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Caroline

City or town Federalsburg

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Lulu Wright

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married.

6.(b) Name of husband or wife Herman Wright

6.(c) If alive, give age 70 years

7. Birth date of deceased (mo., day, yr.) April 26" 1875

8. AGE:

Years	Months	Days	If less than one day
72	1	5	....hrs. ....min.

9. Birthplace Federalsburg, Md.
(Town, county, and state)

10. Usual occupation House-Work.

11. Industry or business Own Home.

FATHER

12. Name Eli P. Cruikett.

13. Birthplace Federalsburg, Md.

MOTHER

14. Maiden name Mary Ann Pennewell

15. Birthplace Sussex Co. Del.

16. Informant Mrs. Lester Collins

Address Federalsburg, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 2" 1947 (month) (day) (year)

Cemetery or crematory Hill-Crest Cemetery

Location Federalsburg, Md.

18. Funeral director S. S. Framptom & Son

Address Federalsburg, Md.

19. 6/2 1947 (Date rec'd by registrar) M. H. Norris Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 31st 1947, at 2:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1 May 1947, to 31 May 1947 and that I last saw h.. alive on 30 May 1947

Immediate cause of death	DURATION
Cerebral hemorrhage	24 hrs.
Due to cerebral arteriosclerosis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE James Ten Harrison M.D. M. D. or other

Address Easton Maryland Date signed 4 June 47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

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JUN 9 1947
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